Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NATIONAL MEDICAL EQUIPMENT AND SUPPLIES
PO BOX 940008
HOUSTON TX 77094

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS BUILDERS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-1830-01

MFDR Date Received
FEBRUARY 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $845.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The service was disputed on the basis of lack of pre-authorization and medical necessity. This medical dispute should be dismissed as the insurance carrier has not record of the provider requesting reconsideration of this bill. Division Rule 133.250(h) requires that the provider request reconsideration of the bill before filing for medical dispute resolution. Further, Division Rule 130.250(b) mandates that a request for reconsideration by [sic] filed no later than eleven months from the date of service. The Provider's deadline for filing a request for reconsideration has expired."

Response Submitted by: Parker & Associates, LLC, 7600 Chevy Chase Dr., Bldg. Two, Ste. 350, Austin, TX 78752

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2010	CPT Code E0745 and E0731	$845.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out the procedure for requesting reconsideration on medical bills.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 5, 2010

- 197 – Payment adjusted for absence of precent/preauth
- T13 – Med necessity denial. Appeal within 11 mos of DOS
- 50 – Service not deemed 'medically necessary' by payer
- ODG – Services exceed ODG guidelines; preauth is required

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the health care provider request reconsideration in accordance with 28 Texas Administrative Code §133.250?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(A), effective May 25, 2008, 33 TexReg 3952, requires that the provider shall include a copy of all medical bills(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with 28 Teas Administrative Code §133.250. The documentation submitted by the requestor does not contain the medical bill submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).
2. 28 Texas Administrative Code §133.250(h), effective May 2, 2006, 31 TexReg 3544, states that If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General). The Division concludes that the requestor has not met the requirements of §133.250(h)
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307 and §133.250.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 6, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.